



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Program Review
of the Memphis VA Medical
Center

Memphis, Tennessee



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Figure 1. Memphis VA Medical Center, Memphis, Tennessee
(Source: <https://vaww.va.gov/directory/>. Accessed on April 27, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Memphis VA Medical Center (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-Term Care;
8. Women's Health; and
9. High-Risk Processes.

This review was conducted during an unannounced visit made during the week of January 29, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Management Council having oversight for leadership groups, such as the Clinical Executive; Environment of Care; ADPCS; and Quality, Safety and Value Boards.

The OIG found that, generally, these leaders were fairly new to their roles. The Assistant Director began working in that position in October 2017, and the remaining executive leaders had been working together as a team since May 2017.

In the review of selected employee and patient survey results regarding Facility senior leaders, the OIG noted employee satisfaction scores higher than the Veterans Health Administration (VHA) average; this reflected active engagement with employees. However, the OIG also noted that each of the selected patient survey results reflected lower care ratings compared to the VHA average. Facility leaders have many opportunities to improve patient satisfaction with care provided.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within the VHA.¹ Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current “1-Star” rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and patient safety indicator data. The OIG identified substantial organizational risks demonstrated through the Patient Safety Indicator data; and, after onsite discussions, Facility leaders have implemented actions to improve patient care by optimizing patients’ overall health status prior to surgery.

Of the eight areas of clinical operations reviewed, the OIG noted findings in six and issued 13 recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

¹ VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star” ranking system to designate a facility’s performance in individual measures, domains, and overall quality.

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews and utilization management.² However, the OIG noted a deficiency with the use of VHA's WebSPOT³ database to document all applicable fiscal year 2017 patient incidents that warranted a recommendation for improvement.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation processes.

Environment of Care

The OIG noted that general safety and privacy measures were in place at the parent Facility and representative community based outpatient clinic and did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies that warranted recommendations for improvement in environment of care rounds, safety, cleanliness, logistics storage areas, and medication safety at the parent Facility and in safety, cleanliness, and maintaining clear egress at the representative community based outpatient clinic.

Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated, including the Controlled Substance Coordinator reports, annual physical security surveys, and ordering procedures. However, the OIG identified a deficiency in controlled substance inspector annual training.

Long-term Care

The OIG noted compliance with providing geriatric evaluations. However, the OIG identified a deficiency with assessing the program for performance improvement.

² VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

³ WebSPOT is the software application used for reporting and documenting adverse events in the VHA Patient Safety Information System.

High-Risk Processes

The OIG noted compliance with having a policy on the use, care, and maintenance of central lines; performing an annual infection prevention risk assessment; routinely reviewing central line-associated bloodstream infection data and prevention measures; educating patients/families; and using a checklist for central line insertions and maintenance. However, the OIG identified a deficiency with training for clinical staff.

Summary

In the review of key care processes, the OIG issued 13 recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 62–63, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions until they are completed.



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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Memphis VA Medical Center (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.^{4,5} Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.⁶ As noted in Figure 2, leadership and organizational risks can positively or negatively affect processes used to deliver care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management; Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women’s Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).⁷

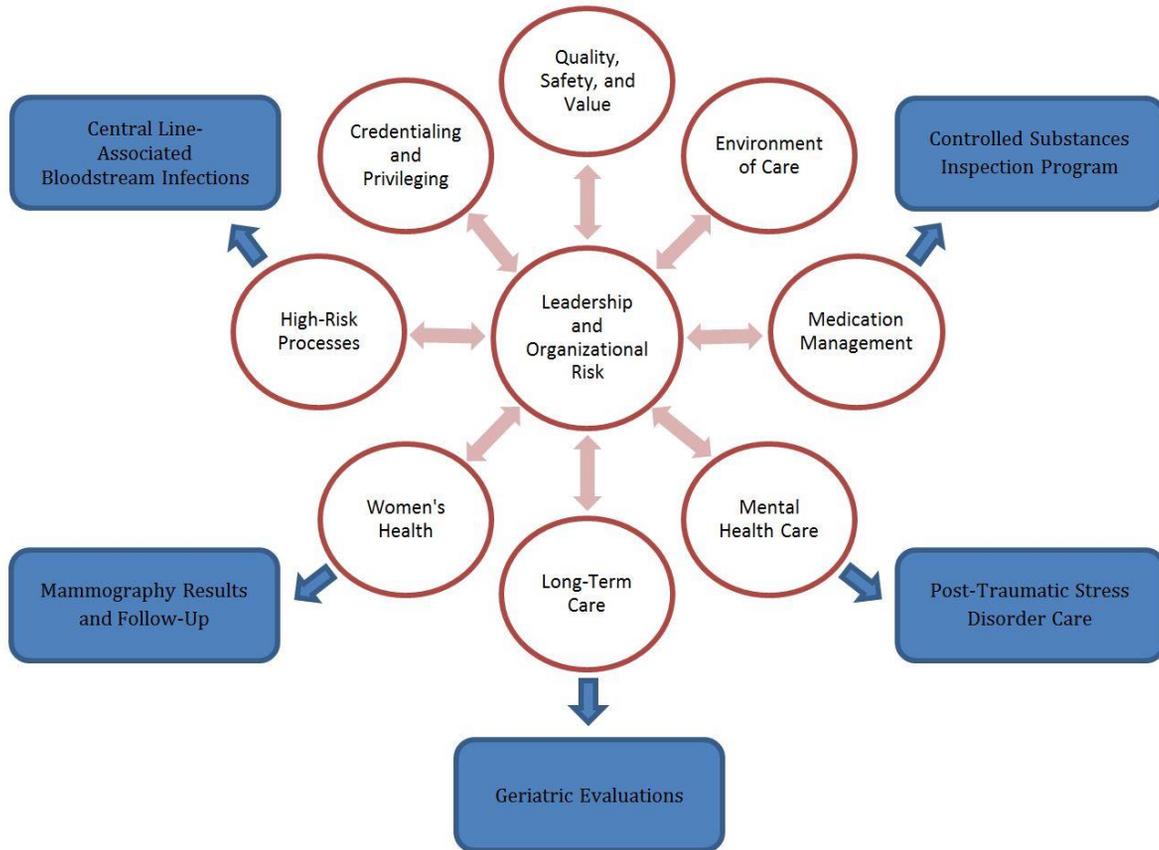
⁴ Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

⁵ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, “The role of hospital managers in quality and patient safety: a systematic review,” *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (Website accessed on March 1, 2018.)

⁶ Institute for Healthcare Improvement, “How risk management and patient safety intersect: Strategies to help make it happen”, March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (Website accessed March 1, 2018.)

⁷ CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

**Figure 2. FY 2018 Comprehensive Healthcare Inspection Program
Review of Healthcare Operations and Services**



Source: VA OIG

Additionally, OIG staff provided crime awareness briefings to increase Facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to the OIG.



Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;⁸ and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for November 3, 2014,⁹ through January 29, 2018, the date when an unannounced week-long site visit commenced. On February 28–March 2, 2018, the OIG presented crime awareness briefings to 183 of the Facility’s 2,507 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

This report’s recommendations for improvement target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the Facility completes corrective actions. The Facility Director’s comments submitted in response to the recommendations in this report appear within each topic area.

While onsite, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁸ The OIG did not review VHA’s internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

⁹ This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.



Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all of the selected clinical areas of focus.¹⁰ To assess the Facility's risks, the OIG considered the following organizational elements

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

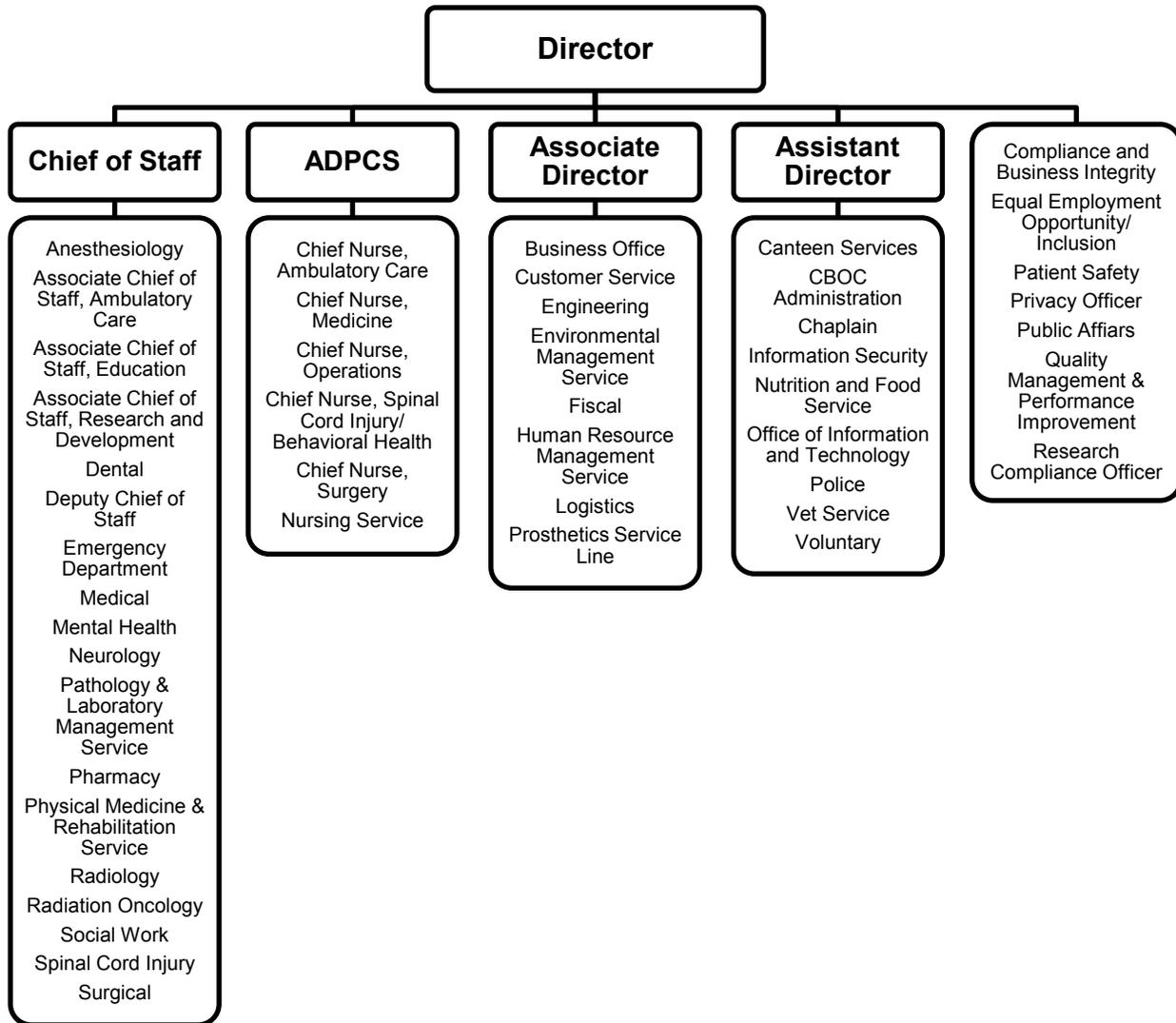
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service and program chiefs.

It is important to note that the Assistant Director began working in that position in October 2017. With this one exception, the executive leaders had been working together as a team since May 2017.

¹⁰ L. Botwinick, M. Bisognano, and C. Haraden. "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006.
<http://www.ihl.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx>. (Website accessed February 2, 2017.)

Figure 3. Facility Organizational Chart



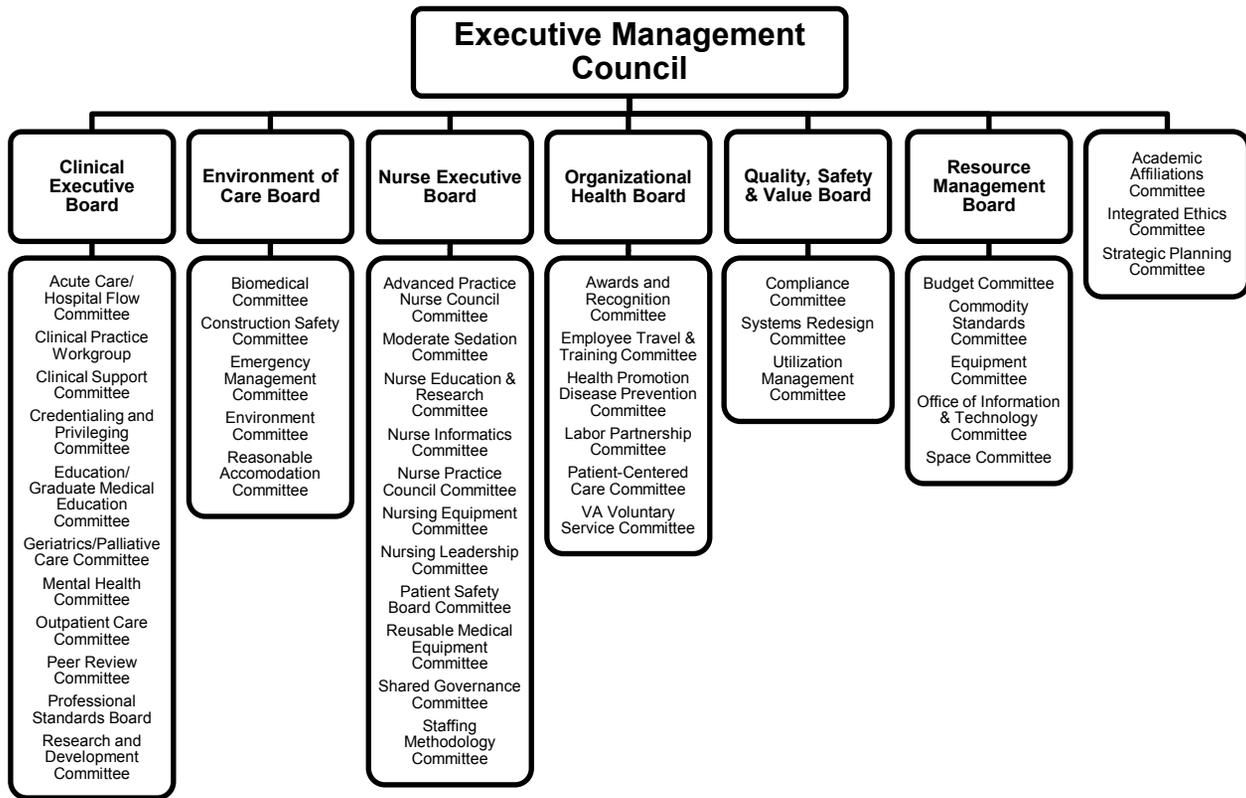
Source: Memphis VA Medical Center (received January 29, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility’s Executive Management Council, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Management Council also oversees various working committees, such as the Clinical Executive; Environment of Care; ADPCS; and Quality, Safety and Value Boards. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Memphis VA Medical Center (received January 29, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017.

Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the Facility. As Table 1 indicates, the Facility leaders’ results (Director’s office average) were rated above the VHA and Facility averages and reflect active engagement with employees.¹¹

**Table 1. Survey Results on Employee Attitudes toward Facility Leadership
 (October 1, 2016, through September 30, 2017)**

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director’s Office Average ¹²
All Employee Survey Q59. <i>How satisfied are you with the job being done by the executive leadership where you work?</i>	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.4	3.9
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	69.0	77.6

Source: VA All Employee Survey (accessed December 29, 2017)

VHA’s Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders. Table 2 shows survey results for the Facility patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. For this Facility, all four patient survey results reflected lower ratings than the VHA average. Opportunities appear to exist to improve patient satisfaction with the leadership and care provided. Facility leaders were working to improve patient satisfaction scores.

¹¹ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

¹² Rating is based on responses by employees who report to or are aligned under the Director.

**Table 2. Survey Results on Patient Attitudes toward Facility Leadership
 (October 1, 2016, through September 30, 2017)**

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	49.1
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	83.4	73.0
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	74.9	65.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	62.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 29, 2017)

Accreditation/For-Cause Surveys¹³ and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC). Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.¹⁴

¹³ TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

¹⁴ A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

The OIG also noted the Facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁵ and College of American Pathologists,¹⁶ which demonstrates the Facility leaders’ commitment to quality care and services. Additionally, the Paralyzed Veterans of America conducted an inspection of the Facility’s spinal cord injury/disease unit and related services.¹⁷

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
<i>OIG (Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee, January 27, 2015)</i>	November 2014	27	0
<i>OIG (Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Memphis VA Medical Center, Memphis, Tennessee, January 15, 2015)</i>	November 2014	14	0
<i>OIG (Healthcare Inspection – Alleged Lack of Timeliness and Quality of Care Concerns at the Memphis VA Medical Center, Memphis, Tennessee, April 16, 2015)</i>	November 2014	0	n/a
TJC ¹⁸	January 2016		
<ul style="list-style-type: none"> • Regular <ul style="list-style-type: none"> ○ Hospital Accreditation ○ Behavioral Health Care Accreditation ○ Home Care Center Accreditation • Follow Up 	June–July 2016	42 1 1 1	0 0 0 0

Sources: OIG and TJC (Inspection/survey results verified with the Director on January 30, 2018)

n/a = not applicable

¹⁵ The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA’s commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

¹⁶ For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

¹⁷ The Paralyzed Veterans of America inspection took place October 4–5, 2016. This Veteran Service Organization review does not result in accreditation status.

¹⁸ TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG’s previous November 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of January 29, 2018.¹⁹

**Table 4. Summary of Selected Organizational Risk Factors
 (November 2014 to January 29, 2018)**

Factor	Number of Occurrences
Sentinel Events ²⁰	6
Institutional Disclosures ²¹	9
Large-Scale Disclosures ²²	0

Source: Memphis VA Medical Center’s Patient Safety Manager (received January 31, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²³ The rates presented are specifically applicable for this Facility, and lower rates

¹⁹ It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Memphis VA Medical Center is a highest complexity (1a) affiliated Facility as described in Appendix B.)

²⁰ A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

²¹ Institutional disclosure of adverse events (sometimes referred to as “administrative disclosure”) is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during the course of care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.

²² Large-scale disclosure of adverse events (sometimes referred to as “notification”) is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

²³ Agency for Healthcare Research and Quality website. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

**Table 5. Patient Safety Indicator Data
 (October 1, 2015, through September 30, 2017)**

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 9	Facility
Pressure ulcers	0.60	0.85	1.96
Death among surgical inpatients with serious treatable conditions	100.97	102.17	164.95
Iatrogenic pneumothorax	0.19	0.17	0.00
Central venous catheter-related bloodstream infection	0.15	0.15	0.45
In-hospital fall with hip fracture	0.08	0.08	0.00
Perioperative hemorrhage or hematoma	1.94	2.61	4.46
Postoperative acute kidney injury requiring dialysis	0.88	0.46	2.60
Postoperative respiratory failure	5.55	5.36	10.57
Perioperative pulmonary embolism or deep vein thrombosis	3.29	4.95	8.53
Postoperative sepsis	4.00	7.78	26.69
Postoperative wound dehiscence	0.52	0.59	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.65	0.98

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

The Patient Safety Indicator measures show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 9 and VHA for:

- Pressure Ulcers,
- Death among surgical inpatients with serious treatable conditions,
- Central Venous Catheter-Related Bloodstream Infection,
- Perioperative Hemorrhage or Hematoma,
- Postoperative Acute Kidney Injury Requiring Dialysis,
- Postoperative Respiratory Failure,
- Perioperative Pulmonary Embolism or Deep Vein Thrombosis,
- Postoperative Sepsis, and

- Unrecognized Abdominopelvic Accidental Puncture/Laceration.

The Facility had an active process for oversight of adverse events through Quality, Safety and Value Board reviews. This committee reviews all Patient Safety Indicator data to identify, monitor, and trend all identifiable adverse events and support improvements. This committee reports directly to the Executive Management Council.

Nine patients developed pressure ulcers while being hospitalized at the Facility. Nursing leaders initially attributed this to a deficient level of nurse training and staffing in acute care. Facility leaders reported that recruitment and hiring processes are ongoing for existing acute care nursing staff vacancies and that they have five new certified wound care nurse specialists assigned throughout the hospital. These nurse specialists are subject matter experts in applying and individualizing measures for preventing and/or reducing the risks for pressure ulcers in hospitalized patients.

Sixteen surgical inpatients with serious treatable conditions died while receiving care at the Facility. In each of these cases, Facility review processes had determined that high-risk patients had known pre-existing, complex, and comorbid health conditions that had not been optimized prior to being selected and/or cleared for surgery. Facility leaders identified a serious breakdown in communication/consultation with all providers involved in the patients' overall care, and they had taken actions to resolve these serious problems prior to our visit.

Two patients developed central venous catheter related bloodstream infections, and 19 patients developed postoperative sepsis. Facility leaders stated this was directly attributable to a deficient number of acute care nursing staff, inefficient nursing staff training, and a lack of infection control/prevention protocols and follow up. As a result, Facility leaders took several actions, including procuring additional training resources and continuing recruitment efforts. Further, a Central Line Policy Revision Steering Team was created and a Central Line Audit Tool was implemented at the end of May 2017 to monitor and track central line issues. This allows an analysis to be performed on each central venous catheter related bloodstream infection identified. Steering team members provide this information in real-time to the units/individuals involved. Facility leaders also established and implemented a new Sepsis Campaign Program. This program has mainly focused on infection prevention protocols for reducing the risk of future reoccurrences and establishes additional supportive resources for acute care staff.

In addition, six patients sustained a perioperative hemorrhage or hematoma, two patients developed an acute injury post-operatively that required dialysis, five patients developed postoperative respiratory failure, 12 patients developed pulmonary embolism or deep vein thrombosis, and one patient had unrecognized abdominopelvic accidental puncture/laceration. All 26 patients had comorbid and complex health conditions prior to being cleared for surgery; and, again, Facility leadership attributed inefficient provider communication/consultation processes, lack of rigorous surgical case review/selection, and lack of surgical case decision protocols to these patient complications and poor outcomes. Facility leaders reported that all

surgical cases now undergo stringent review/selection, all providers involved in the patients' overall care are consulted before pre-surgical case decisions are finalized, and the patients' complex medical health condition(s) are optimized prior to surgery. The Director stated that prior to our visit, a new Surgery Service Chief and Quality Management Manager had been hired; and, along with the Deputy Chief of Staff, all parties are continuously involved with Surgical Service oversight.

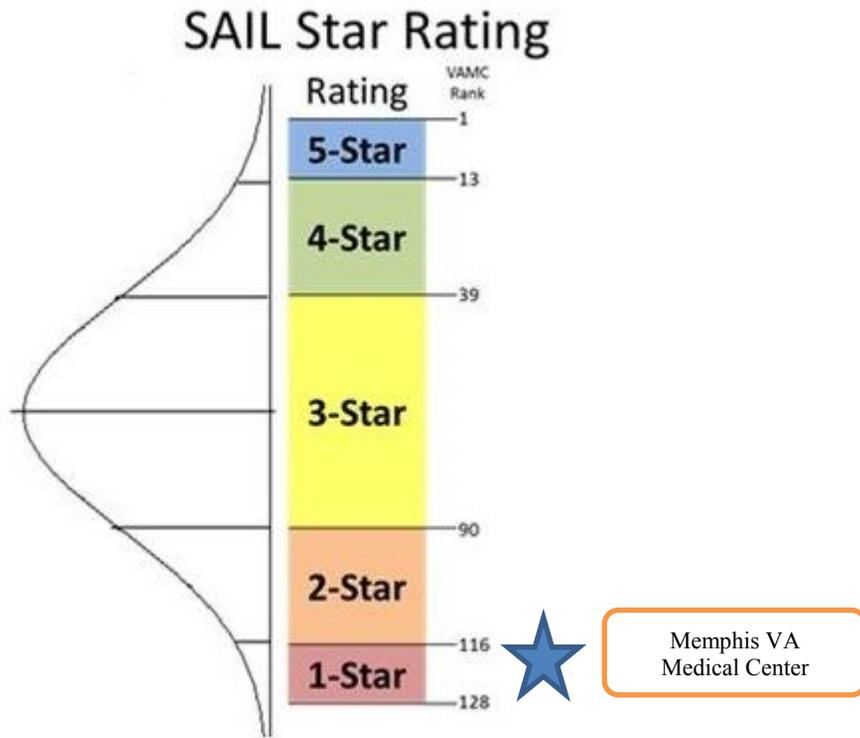
Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁴ As of June 30, 2017, the Facility received a rating of "1-Star" for overall quality.

²⁴ Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

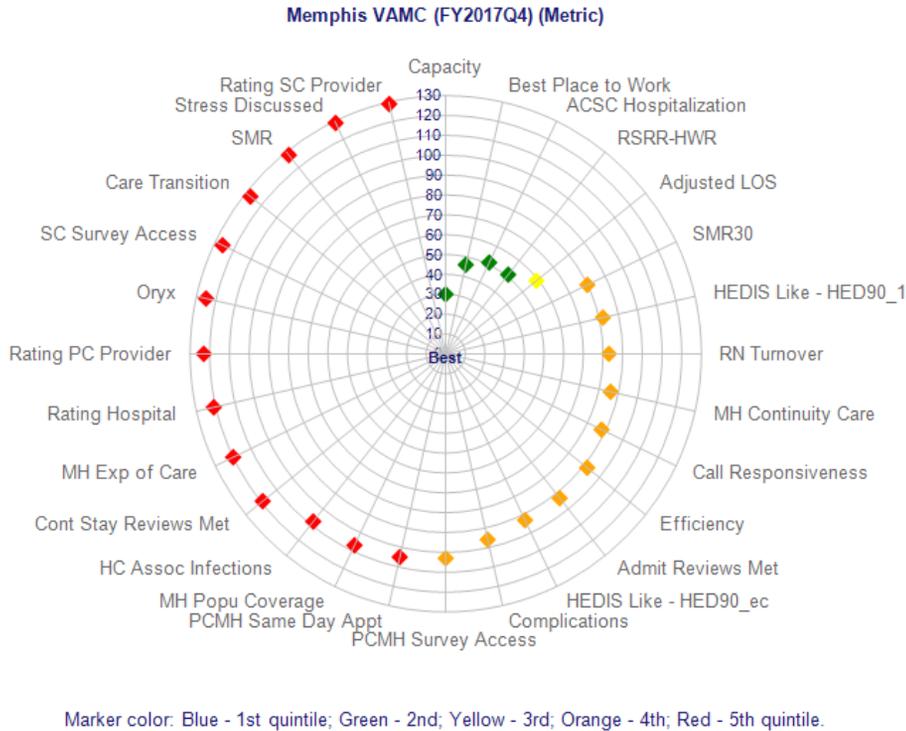


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (accessed December 29, 2017)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Capacity, Best Place to Work, and Ambulatory Care Sensitive Condition (ACSC) Hospitalization).²⁵ Metrics in that need improvement are denoted in orange and red (for example, RN (registered nurse) Turnover, Complications, Rating (of) Hospital, and Care Transition).

²⁵ For data definitions of acronyms in the SAIL metrics, please see Appendix D.

**Figure 6. Facility Quality of Care and Efficiency Metric Rankings
 (as of September 30, 2017)**



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix D.

Conclusion

The Facility has generally stable executive leadership and active engagement with employees as evidenced by satisfaction scores. However, multiple opportunities appear to exist to improve the patient experience of care. Organizational leaders appear to support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to improve positive perceptions of the Facility through active stakeholder engagement). However, OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results identified recent delivery of poor care and substantial future organizational risks if improvements are not made. Facility leaders have implemented actions to improve patient care and employee engagement and should continue to monitor these actions to ensure that they are effective in improving patient outcomes. Further, the senior leadership team appeared to be knowledgeable about selected SAIL metrics and should continue to take actions

to improve care and performance of Quality of Care and Efficiency metrics likely contributing to the current “1-Star” rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.²⁶ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.²⁷

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,²⁸ utilization management (UM) reviews,²⁹ and patient safety incident reporting with related root cause analyses (RCAs).³⁰

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.³¹

²⁶ VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

²⁷ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

²⁸ According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

²⁹ According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

³⁰ According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to VHA National Center of Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

³¹ VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:³²

- Protected peer reviews
 - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Entry of all reported patient incidents into WebSPOT³³
 - Annual completion of a minimum of eight RCAs³⁴
 - Provision of feedback about RCA actions to reporting employees
 - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for protected peer reviews and UM. However, the OIG identified the following deficiencies in patient safety that warranted recommendations for improvement.

³² For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

³³ WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

³⁴ According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

Patient Safety Events

VHA requires that patient safety events be reported and documented in WebSPOT.³⁵ This process provides data that is used to track and trend patient safety incidents across VHA. For 2017, there were a total of 1,151 electronic patient incidents reported; however, only 848 incidents (55 percent) were entered into WebSPOT. Facility managers cited the lack of a functioning local server and staff as the reasons for noncompliance.

Recommendation 1

1. The Facility Director ensures Facility staff enter all patient incidents into WebSPOT or the VHA Patient Safety Information System and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: The Chief, Quality Management, and the Interim Chief, Human Resources, worked together to expedite the hiring of a registered nurse who will enter and score the remaining FY17 patient incidents into WebSPOT. The process for entering the FY17 incidents has begun. This response will be monitored by the Patient Safety Manager monthly until 100 percent compliance is achieved. Additionally, the Medical Center Director has approved hiring a full-time Patient Safety Specialist who will work with the Patient Safety Manager in Quality Management.

³⁵ VHA Handbook 1050.01.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).³⁶

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.³⁷

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual’s license. Clinical privileges need to be specific, based on the individual’s clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.³⁸

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,³⁹ and 20 LIPs who were re-privileged within 12 months prior to the visit.⁴⁰ The OIG evaluated the following performance indicators:

- Credentialing
 - Current licensure
 - Primary source verification
- Privileging
 - Verification of clinical privileges
 - Requested privileges

³⁶ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

³⁷ VHA Handbook 1100.19.

³⁸ VHA Handbook 1100.19.

³⁹ The 18-month period was from July 29, 2016, through January 29, 2018.

⁴⁰ The 12-month review period was from January 29, 2017, through January 29, 2018.

- Facility-specific
- Service-specific
- Provider-specific
- Service chief recommendation of approval for requested privileges
- Medical Staff Executive Committee decision to recommend requested privileges
- Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
 - Evaluation initiated
 - Timeframe clearly documented
 - Criteria developed
 - Evaluation by another provider with similar training and privileges
 - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
 - Determination to continue privileges
 - Criteria specific to the service or section
 - Evaluation by another provider with similar training and privileges
 - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified the following deficiencies in FPPE and OPPE processes that warranted recommendations for improvement.

FPPE Completion

VHA requires that all LIPs new to the Facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate medical staff committee.⁴¹ The process involves the evaluation of privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges at the Facility.

⁴¹ VHA Handbook 1100.19.

This process may include periodic chart reviews, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.⁴² For 3 of 10 newly hired LIPs, FPPEs were not initiated. The Chief of Staff stated FPPEs were not initiated due to the lack of compliance by select service chiefs who are no longer employed at the Facility.

Recommendation 2

2. The Chief of Staff ensures service chiefs initiate and complete Focused Professional Practice Evaluations on all newly hired Licensed Independent Providers and monitors compliance

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: Initiation and completion of Focused Professional Practice Evaluations (FPPEs) for newly hired Licensed Independent Providers will now be tracked monthly in Clinical Executive Board. Service Chiefs will submit copies of signed, initiated FPPEs prior to the monthly Clinical Executive Board. Completed FPPEs will also be submitted to Clinical Executive Board. This will be monitored by Chief of Staff's Office until three sequential months demonstrate 90 percent compliance.

OPPE Completion

VHA requires that at the time of reprivileging, service chiefs consider relevant, service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIPs' privileges to the Executive Committee of the Medical Staff. Such data is maintained as part of the practitioner's provider profile and may include direct observation, clinical discussions, and clinical reviews. This OPPE is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and patient safety.⁴³ For 6 of 20 provider profiles reviewed, there was no evidence that the determination to continue current privileges was based on the results of OPPE data. The Chief of Staff acknowledged the deficiencies and stated the OPPE process was not followed by select service chiefs who are no longer employed at the Facility.

⁴² VHA Handbook 1100.19.

⁴³ VHA Handbook 1100.19.

Recommendation 3

3. The Chief of Staff ensures that service chiefs include review of relevant data in Ongoing Professional Practice Evaluations to determine continuation of current privileging for Licensed Independent Providers and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: Prior to signing the continuation of current privileges, the Chief of Staff, or Designee, will review the Service Chiefs' documentation to ensure the review of relevant service-specific data in Ongoing Professional Practice Evaluations (OPPEs) has been used to determine continuation of current privileges for Licensed Independent Providers. This will be monitored by Chief of Staff's Office until three sequential months demonstrate 90 percent compliance.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁴⁴

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.⁴⁵ The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on construction safety⁴⁶ and Nutrition and Food Services processes.⁴⁷

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.⁴⁸

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have annual hazard analysis critical control point food safety plan, food services inspections, food service emergency operations plan, and safe food transportation and storage practices.⁴⁹

In all, the OIG team inspected four inpatient units (medical intensive care, 2S-medical/telemetry, 3F-surgical, 1C/1D-MH), the post-anesthesia care unit, the surgical outpatient clinic, the Emergency Department, the Nutrition and Food Services area, and two construction sites. The OIG also inspected the Covington North CBOC.⁵⁰ Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention/Infection Control Committee

⁴⁴ VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

⁴⁵ Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁴⁶ VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

⁴⁷ VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

⁴⁸ VHA Directive 7715.

⁴⁹ VHA Handbook 1109.04.

⁵⁰ Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent Facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

minutes for the past 6 months, other relevant documents, and interviewed key employees and managers. The OIG reviewed the following location-specific performance indicators:

- Parent Facility
 - EOC rounds
 - EOC deficiency tracking
 - Infection prevention
 - General safety
 - Environmental cleanliness
 - General privacy
 - Women veterans' exam room privacy
 - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
 - General safety
 - Medication safety and security
 - Infection prevention
 - Environmental cleanliness
 - General privacy
 - Exam room privacy
 - Availability of medical equipment and supplies
- Construction Safety
 - Completion of infection control risk assessment for all sites
 - Infection Prevention/Infection Control Committee discussions on construction activities
 - Dust control
 - Safety and security

- Selected requirements based on project type and class⁵¹
- Nutrition and Food Services
 - Annual Hazard Analysis Critical Control Point Food Safety System plan
 - Food Services inspections
 - Emergency operations plan for food service
 - Safe transportation of prepared food
 - Environmental safety
 - Infection prevention
 - Storage areas

Conclusion

The OIG found general safety and privacy measures were in place at the parent Facility and representative CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility's Environment of Care Rounds Attendance

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality of care environment.⁵² From October 1, 2016, through September 30, 2017, 10 of 13 required members did not participate in EOC rounds consistently. This resulted in a lack of adequate subject matter experts during the rounds. The missing team members reported confusion about which sessions to attend when rounds were conducted more than once a week, resulting in noncompliance.

⁵¹ VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generated a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the Emergency Department, inpatient medical and surgical units, and the pharmacy.

⁵² According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

Recommendation 4

4. The Associate Director ensures required team members consistently participate on environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: In April 2018 the Safety Office began running a weekly report that is forwarded to the Assistant Director which identifies the EOC members that were delinquent for EOC Rounds. On October 1, 2017, the EOC Committee reduced the rounds from three times a week to once weekly to lessen the confusion about EOC Rounds attendance and began addressing EOC Round attendance with those non-compliant services. This will be monitored to ensure a consistent 90 percent attendance.

Parent Facility: Safety and Cleanliness

TJC requires hospitals to identify and resolve environmental deficiencies, hazards, and unsafe practices and to keep furnishings and equipment safe and in good repair.⁵³ This ensures a clean and safe healthcare environment. The OIG noted problems with cleanliness and maintenance of overhead structures throughout the parent Facility. Of the seven patient care areas inspected, two had soiled furniture,⁵⁴ all had dirty ventilation grills,⁵⁵ five had dirty floors,⁵⁶ four had stained ceiling tiles,⁵⁷ and one had missing ceiling tiles.⁵⁸ Environmental Management Service (EMS) housekeeping staff were not following room cleaning procedures, and EMS supervisors did not consistently identify or address these deficiencies during Facility EOC rounds.

Recommendation 5

5. The Associate Director ensures Facility managers maintain a safe and clean environment throughout the Facility and monitors compliance.

⁵³ TJC. Environment of Care: EC.02.06.01, EP20 and EP26, and EC.04.01.01.

⁵⁴ 2S-medical/telemetry unit and post-anesthesia care.

⁵⁵ Medical intensive care, 2S-medical/telemetry, 3F-surgical, 1C/1D-MH, and post-anesthesia care units; the Emergency Department; and the surgical outpatient clinic.

⁵⁶ 2S-medical/telemetry, 3F-surgical, and 1C/1D-MH units; the Emergency Department; and the surgical outpatient clinic.

⁵⁷ 2S-medical/telemetry and 3F-surgical units, the Emergency Department, and the surgical outpatient clinic.

⁵⁸ The surgical outpatient clinic.

Facility concurred.

Target date for completion: Ceiling Tiles Monitor – October 31, 2018
Furniture Replacement – December 31, 2018
Ventilation Grill Replacement – March 31, 2018

Facility response: The stained and missing ceiling tiles have been replaced. Engineering Service has developed a protocol for ceiling tile inspections that ensures each building receives a complete monthly inspection for missing and/or stained ceiling tiles, in addition to the ongoing EOC Rounds being performed. Repeat issues are tracked and trended to ensure that the source of the problem is corrected. The number of repeat ceiling tile issues will be tracked with an anticipated reduction of repeat ceiling tile findings by 90 percent within 6 months.

Engineering Service compiled a list of replacement furniture needed throughout the Facility which includes the soiled furniture. The anticipated completion of replacement of 100 percent of soiled furniture is December 31, 2018. This will be monitored by Engineering Service to ensure the goal is met. EMS prioritized cleaning fabric furnishings in all patient care areas beginning April 9, 2018. This project will be monitored by the Interim Chief, EMS, to ensure 100 percent furnishings are cleaned by May 11, 2018.

EMS coordinated with Nursing Service on a patient room floor cleaning project on April 6, 2018, and began with stripping and waxing on 2S. EMS will develop a project schedule to be disseminated to all nursing units for patient room floor cleaning. The Interim Chief, EMS provided copies of the room cleaning Standard Operating Procedure (SOP) to each supervisor for adherence and compliance. The Environmental Care Specialist will monitor patient rooms daily.

Parent Facility: Equipment Storage Areas

VHA requires that bottom shelves in equipment storage areas must be solid or have an impervious shelf liner to prevent contamination of stored items. This ensures that clean and sterile supplies do not fall to the floor where the cleanliness of supplies may be compromised. The OIG noted that three of six applicable areas did not have solid bottom storage shelves.⁵⁹ EMS staff were unaware of missing shelf liners and lacked attention to detail.

Recommendation 6

6. The Associate Director ensures that bottom shelves in equipment storage areas are solid or have impervious shelf liners and monitors compliance.

⁵⁹ 2S-medical/telemetry, 3F-surgical, and 1C/1D-MH units.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: Logistics maintains a stock of solid bottom shelves made of Plexiglas to replace broken, damaged, or missing liners. The three areas identified in the draft report had shelf liners installed during the OIG Review. Logistics conducts a monthly inspection of all the clean supply rooms which includes verifying the presence and integrity of the bottom shelf liners. During the week of April 9-13, 2018, the presence of shelf liners was verified in 100 percent clean storage rooms. This will be monitored until three sequential months demonstrates 100 percent compliance. Logistics staff were educated on the need for bottom shelving in equipment/supply storage areas to ensure cleanliness of supplies is not compromised.

Parent Facility Expired Medications

TJC requires all expired, damaged, and/or contaminated medications to be stored separately from medications available for administration.⁶⁰ This ensures effective and safe medication management and patient safety. Three of seven areas had expired opened medication vials.⁶¹ Staff lacked effective oversight to ensure that medication refrigerators were consistently inspected and expired or damaged medications were removed and returned to Pharmacy.

Recommendation 7

7. The Associate Director ensures clinical staff remove expired medications from patient care areas and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: Nurse Managers round on all units, both inpatient and outpatient clinical areas, using the All Hands on Deck Checklist which includes the item, “Multi-dose vials, if open, labeled to expire in 28 days (check Omnicell refrig)”. The Nurse Executive reminded Nurse Managers to ensure expired meds are removed as required and to include this in their daily refrigerator check. This instruction has been given and will be repeated in staff meetings. This will be monitored by Nurse Managers for three consecutive months with a goal of 100 percent compliance at each inspection. Monitoring will be ongoing and reported to the appropriate Chief Nurse.

⁶⁰ TJC. Medication Management: MM.03.01.01, EP8.

⁶¹ Medical Intensive care, 3F-surgical, and 1C/1D-MH units.

CBOC Safety and Cleanliness

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices; and keep furnishings and equipment safe and in good repair. This ensures a clean and safe healthcare environment.⁶² At the Covington North CBOC, 7 of 12 examination tables had rust and torn upholstery that could not be cleaned/sterilized. Work orders had been placed for replacement of the examination tables. All 12 examination rooms were dirty and had stained walls. In addition, the main waiting room was dusty, dirty, and had soiled furniture. The cleaning service staff were not VA employees and were not following room cleaning procedures. Furthermore, EMS supervisors did not identify or address these deficiencies during EOC rounds due to lack of attention to detail.

Recommendation 8

8. The Associate Director ensures the Facility managers maintain a safe and clean environment at the Covington North Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: Exam Tables Replaced – Completed
Furniture Replacement – December 31, 2018

Facility response: All examination tables that were rusted and torn at the North CBOC have been replaced. Engineering Service compiled a list of replacement furniture needed throughout the North CBOC which includes the soiled furniture. The replacement of soiled furniture will be monitored to ensure 100 percent replacement by December 31, 2018.

At the North CBOC, the existing cleaning company was replaced on April 2, 2018, to ensure a clean healthcare environment. Engineering Service is performing bi-weekly rounds with the Lessor to monitor cleanliness and overall Clinic appearance. To ensure appropriate performance of the new cleaning company, Engineering Service contracting officer representatives will monitor performance until three sequential months demonstrates 95 percent of cleaning issues are resolved and a clean environment is maintained.

CBOC Means of Egress

TJC requires means of egress to be clear of obstructions.⁶³ This allows patients and staff to escape from fire and other emergencies without delay. The OIG noted egress obstructions

⁶² TJC. Environment of Care: EC.02.06.01, EP20 and EC.04.01.01, EP14.

⁶³ TJC. Life Safety: LS.02.01.20.

(electrocardiogram machines) in the Covington North CBOC's main hallway and the laboratory area. CBOC Managers reported the lack of storage space for the medical equipment and admitted that staff also lacked attention to detail and did not maintain clear escape routes for emergencies.

Recommendation 9

9. The Associate Director ensures that Community Based Outpatient Clinic staff maintain clear means of egress at the Covington North Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: The electrocardiogram machines were moved into the Clinic Conference Room on January 31, 2018, after the OIG CHIP Inspectors left the Clinic. This was established as the permanent storage place when the machines are not in use. All staff were re-educated on January 31, 2018, on the egress requirements to provide Veteran, visitor, and employee safety and to ensure compliance to The Joint Commission requirement, i.e.:

Standard LS.02.01.20 – The hospital maintains the integrity of the means of egress.

EP14 - Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice.

The Clinic Nurse Manager, or designee, will conduct random observations of the hallways and corridors for any obstruction of the egress. These observations will be done 5 times per week until a sequential three months reflects 95 percent compliance rate. The results will be reported to the Chief Nurse, Ambulatory Care. Also, checking for obstruction of corridors and egress hallways has been added to the monthly EOC rounds checklist conducted by the Clinic Nurse Manager.

Parent Facility Nutrition and Food Service Cleanliness

VHA requires that exhaust air ducts and ventilation grills be kept clean to prevent contamination from dust, dirt, and other foreign materials.⁶⁴ The OIG noted dusty and dirty air ducts and ventilation grills in the food service and storage areas. This resulted in the inability to ensure food was free from contamination. Facility managers stated that current EMS staffing challenges

⁶⁴ VHA Handbook 1109.04.

prevent adherence to a consistent cleaning schedule for the food service areas, and EMS supervisors and the Facility EOC rounds process did not identify or address these deficiencies.

Recommendation 10

10. The Associate Director ensures that environmental management service staff maintain clean air ducts and ventilation grills in food service and storage areas and monitors compliance.

Facility concurred.

Target date for completion: May 31, 2018

Facility response: The air ducts were cleaned in February 2018. Engineering Service will replace the air ducts and ventilation grills in food service and storage areas by May 31, 2018.

Air ducts and ventilation grills in Food Service and storage areas are included in the weekly Nutrition and Food Service (NFS) inspection form for identifying dust or dirty air ducts needing cleaning. A Designated Supervisor completes weekly inspections (rotates monthly among the Supervisors). When air ducts and ventilation grills are identified as needing attention, work orders are submitted for cleaning the day of the inspection. In addition to the weekly inspections, the air ducts and ventilation grills are monitored during monthly EOC inspections. NFS Supervisors will monitor air ducts and ventilation grills during routine rounds with a compliance goal of 95 percent at each inspection.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.⁶⁵ Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.⁶⁶

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.⁶⁷ Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.⁶⁸ The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;⁶⁹ monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;⁷⁰ CS inspection quarterly trend reports for the prior four quarters;⁷¹ and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
 - Monthly summary of findings to the Director
 - Quarterly trend report to the Director
 - Actions taken to resolve identified problems

⁶⁵ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (Website accessed on August 21, 2017.)

⁶⁶ American Society of Health-System Pharmacists, “ASHP Publishes Controlled Substances Diversion Prevention Guidelines,” October 2016. <https://www.ashp.org/news/2017/03/10/19/22/ashp-publishes-controlled-substances-diversion-prevention-guidelines>. (Website accessed on August 21, 2017.)

⁶⁷ VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (*Due for recertification November 30, 2015, but has not been updated*); VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

⁶⁸ VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

⁶⁹ The review period was April 2017 through September 2017.

⁷⁰ The review period was October 2016 through September 2017.

⁷¹ The four quarters were from October 2016 through September 2017.

- Pharmacy operations
 - Annual physical security survey of the pharmacy/pharmacies by VA Police
 - CS ordering processes
 - Inventory completion during Chief of Pharmacy transition
 - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
 - Free from conflicts of interest
 - CSC duties included in position description or functional statement
 - Completion of required CSC orientation training course
- Requirements for CSIs
 - Free from conflicts of interest
 - Appointed in writing by the Director for a term not to exceed three years
 - Hiatus of one year between any reappointment
 - Completion of required CSI certification course
 - Completion of required annual updates and/or refresher training
- CS area inspections
 - Monthly inspections
 - Rotations of CSIs
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of CS orders
 - CS inspections performed by CSIs
- Pharmacy inspections
 - Monthly physical counts of the CS in the pharmacy by CSIs
 - Completion of inspections on day initiated

- Security and documentation of drugs held for destruction⁷²
- Accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated including CSC reports, annual physical security surveys, and ordering procedures. However, the OIG identified the following deficiency that warranted a recommendation for improvement.

Controlled Substance Inspectors Annual Training

VHA requires that all CSIs receive annual updates and/or refresher training regarding problematic issues.⁷³ This ensures that the CSIs are able to identify trends through reviewing external surveys and monthly and quarterly reports. For the 17 applicable CSIs, the OIG did not find evidence that they completed annual updates or refresher trainings. The CSC stated that the CSIs completed annual CSI refresher trainings, but the CSC failed to document all training sessions.

Recommendation 11

11. The Facility Director ensures the Controlled Substance Coordinator completes and documents annual controlled substance inspector training and monitors compliance.

⁷² The “Destructions File Holding Report” lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

⁷³ VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016.

Facility concurred.

Target date for completion: May 31, 2018

Facility response: The CSC has scheduled annual training for the CSIs on May 22, 2018. This training will allow time for the CSIs to complete the annual Talent Management Service (TMS) Training, "Controlled Substance Inspector Certification Course," per Directive 1108.02, March 6, 2017. Inspectors not able to come to the May 22 training will have until May 31, 2018, to complete the TMS Training, give the CSC a copy of the certificate, and review the VHA Directive and the local CSI Program Policy. Other topics to be addressed are the most recent CS Inspection Quarterly Report, accessing the Behavioral Health Unit, and updates to VHA Directive 1108.02 and the Memphis local policy on the CSI Program. This will be monitored until 100 percent compliance is achieved. The CSC will conduct additional refresher/update sessions for the Inspectors throughout FY18 that will include information received from the VA National CSC Group and the National CSC SharePoint site on data trends and problematic issues.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) may occur “following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one’s physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate.”⁷⁴ For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.⁷⁵

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.⁷⁶ VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient’s PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.⁷⁷

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 32 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

⁷⁴ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (Due for recertification March 31, 2015, and revised December 8, 2015, but has not been updated.)

⁷⁵ VHA Handbook 1160.03.

⁷⁶ A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

⁷⁷ VHA Handbook 1160.03.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.⁷⁸ As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.⁷⁹ Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.⁸⁰

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.⁸¹ This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.⁸² Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.⁸³

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 47 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Program oversight and evaluation
 - Evidence of GE program evaluation
 - Evidence of performance improvement activities through leadership board
- Provision of clinical care
 - Medical evaluation by GE provider
 - Assessment by GE nurse

⁷⁸ VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

⁷⁹ VHA Directive 1140.04.

⁸⁰ Chad Boulton, Lisa B. Boulton, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

⁸¹ Public Law 106-117.

⁸² VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

⁸³ VHA Directive 1140.04.

- Comprehensive psychosocial assessment by GE social worker
- Patient or family education
- Plan of care based on GE
- Geriatric management
 - Implementation of interventions noted in plan of care

Conclusion

Generally, the Facility met requirements for providing GE. However, the OIG identified the following opportunities for improvement.

GE Program Evaluation Performance Improvement Activities

VHA requires Facility leaders to assess the GE program and oversee performance improvement activities.⁸⁴ This provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis. The Facility did not evaluate GE processes, identify specific performance measures, or conduct performance improvement activities. The Associate Chief of Staff of Geriatrics and Extended Care stated that noncompliance was due to a lack of support staff.

Recommendation 12

12. The Chief of Staff ensures that Geriatric and Extended Care Service leaders conduct and report geriatric evaluation program performance improvement activities to an appropriate leadership board and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2018

Facility response: The Chief of Staff will ensure that Geriatric and Extended Care Service leaders conduct and report GE program performance improvement activities to the Quality, Safety, and Value Board quarterly. This will be monitored for two quarters with a goal of 100 percent compliance.

⁸⁴ VHA Directive 1140.04.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.⁸⁵ Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.⁸⁶ The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.⁸⁷

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.⁸⁸

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 46 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient
- Performance of follow-up mammogram if indicated

⁸⁵ U.S. Breast Cancer Statistics. <http://www.BreastCancer.org>. (Website accessed on May 18, 2017.)

⁸⁶ Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

⁸⁷ Veterans Health Care Act of 1992, Title I, Pub. L. 102-585 (1992).

⁸⁸ VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (Due for recertification April 30, 2016, but has not been updated.)

- Performance of follow-up study⁸⁹

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

⁸⁹ This performance indicator did not apply to this Facility.

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.⁹⁰ Central lines “refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,”⁹¹ central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.⁹²

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a “primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site.”⁹³

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”⁹⁴ The patient’s age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.⁹⁵

The OIG’s review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 30 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

⁹⁰ TJC. Infection Control and National Patient Safety Goals: IC.01.03.01, EP 4, 5, July 2017.

⁹¹ Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

⁹² These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

⁹³ The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

⁹⁴ The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

⁹⁵ Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the OIG noted that the Facility had a policy on use and care of central lines, had performed an annual infection prevention risk assessment, had evidence of routine reviews of CLABSI data and prevention measures, had education for patients/families, and used a checklist for central line insertions and maintenance. However, the OIG identified the following deficiency with training for clinical staff that warranted the following recommendations for improvement.

CLABSI Prevention Education

TJC requires that all clinical staff who are involved in inserting and managing central lines receive training on CLABSI prevention. This ensures that staff have sufficient knowledge of appropriate infection control measures to reduce the risk of CLABSI. Eleven of 30 employees' training records did not contain evidence of required CLABSI training. These eleven employees were nurses assigned to either the Emergency Department or Interventional Radiology Service. The Emergency Department and Interventional Radiology Service nurse managers stated they were unaware of the training requirement.

Recommendation 13

13. The Associate Director for Patient Care Services ensures that all staff involved in managing central lines receive central line-associated bloodstream infection prevention education and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Facility Response: The Emergency Department (ED) Nurse Manager will ensure that all nurses in the ED complete the TMS Training, “Central Venous Catheter: Infection Prevention (NFED 100600)”. This will be completed by April 30, 2018. The Interventional Radiology (IR) Nurse Manager will also ensure that all nurses working in IR will complete the Central Venous Catheter TMS Training by April 30, 2018. In addition to the staff noted in the OIG CHIP Draft Report, the Executive Nurse has mandated the “Central Venous Catheter: Infection Prevention” TMS Training be completed by all nursing staff involved in managing central lines. Unit Nurse Managers will track and ensure their staff complete the training. This will be monitored until data reflects 100 percent of appropriate nursing staff completed the training.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data 	Thirteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Facility staff enter all patient safety incidents into WebSPOT or the VHA Patient Safety Information System.
Credentialing and Privileging	<ul style="list-style-type: none"> • Medical licenses • Privileges • FPPEs • OPPEs 	<ul style="list-style-type: none"> • Service chiefs initiate and complete FPPEs for all newly hired LIPs. 	<ul style="list-style-type: none"> • Service chiefs include review of relevant data in OPPEs to determine continuation of current privileging for LIPs.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent Facility <ul style="list-style-type: none"> ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Construction Safety <ul style="list-style-type: none"> ○ Infection control risk assessment ○ Infection Prevention/ Infection Control Committee discussions ○ Dust control ○ Safety/security ○ Selected requirements based on project type and class • Nutrition and Food Services <ul style="list-style-type: none"> ○ Annual Hazard Analysis Critical control Point Food Safety System plan ○ Food Services inspections ○ Safe transportation of prepared food ○ Environmental safety ○ Infection prevention ○ Storage areas 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Required team members consistently participate on EOC rounds. • Facility managers maintain a safe and clean environment through the Facility. • Bottom shelves in equipment storage areas are solid or have impervious shelf liners. • Clinical staff remove expired medications from patient care areas. • A safe and clean environment is maintained at the Covington North CBOC. • Staff maintain a clear means of egress at the Covington North CBOC. • EMS staff maintain clean air ducts and ventilation grills in food service and storage areas.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	<ul style="list-style-type: none"> • CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The CSC completes and documents annual CSI training.
Mental Health Care: Post-Traumatic Stress Disorder Care	<ul style="list-style-type: none"> • Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Long-Term Care: Geriatric Evaluations	<ul style="list-style-type: none"> • Program oversight and evaluation • Provision of clinical care • Geriatric management 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Geriatric and Extended Care leaders conduct and report GE program performance improvement activities to an appropriate leadership board.
Women's Health: Mammography Results and Follow-Up	<ul style="list-style-type: none"> • Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Central Line-Associated Bloodstream Infections	<ul style="list-style-type: none">• Policy and infection prevention risk assessment• Committee discussion• Infection incidence data• Education and educational materials• Checklist	<ul style="list-style-type: none">• None	<ul style="list-style-type: none">• All staff involved in managing central lines receive CLABSI prevention education

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a)⁹⁶ affiliated⁹⁷ Facility reporting to VISN 9.

**Table 6. Facility Profile for Memphis (614)
 (October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 ⁹⁸	Facility Data FY 2016 ⁹⁹	Facility Data FY 2017 ¹⁰⁰
Total Medical Care Budget in Millions	\$452.6	\$475.7	\$467.3
Number of:			
• Unique Patients	68,749	68,125	66,612
• Outpatient Visits	668,145	627,508	652,205
• Unique Employees ¹⁰¹	2,005	1,966	1,953
Type and Number of Operating Beds:			
• Domiciliary	16	16	26
• Intermediate	33	33	33
• Medicine	70	76	76
• Mental Health	32	32	32
• Neurology	5	5	5
• Spinal Cord	60	60	60
• Surgery	44	28	28
Average Daily Census:			
• Domiciliary	21	18	18
• Intermediate	n/a	4	13

⁹⁶ The VHA medical centers are classified according to a Facility complexity model; 1a designation indicates a Facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs.

⁹⁷ Associated with a medical residency program.

⁹⁸ October 1, 2014, through September 30, 2015.

⁹⁹ October 1, 2015, through September 30, 2016.

¹⁰⁰ October 1, 2016, through September 30, 2017.

¹⁰¹ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015 ⁹⁸	Facility Data FY 2016 ⁹⁹	Facility Data FY 2017 ¹⁰⁰
• Medicine	66	62	50
• Mental Health	29	25	28
• Neurology	1	1	2
• Spinal Cord	33	31	32
• Surgery	13	14	10

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

n/a = not applicable

VA Outpatient Clinic Profiles¹⁰²

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women’s health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters¹⁰³ and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ¹⁰⁴ Provided	Diagnostic Services ¹⁰⁵ Provided	Ancillary Services ¹⁰⁶ Provided
Tupelo, MS	614GA	10,205	3,889	Cardiology Endocrinology	n/a	Nutrition Pharmacy Social Work Weight Management
Jonesboro, AR	614GB	4,987	1,969	n/a	n/a	Nutrition Weight Management
Holly Springs, MS	614GC	2,125	823	n/a	Laboratory and Pathology	Weight Management

¹⁰² Includes all outpatient clinics in the community that were in operation as of August 15, 2017. The OIG omitted Memphis, TN (614QA), as no workload/encounters or services were reported.

¹⁰³ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

¹⁰⁴ Specialty care services refer to non-PC and non-MH services provided by a physician.

¹⁰⁵ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

¹⁰⁶ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

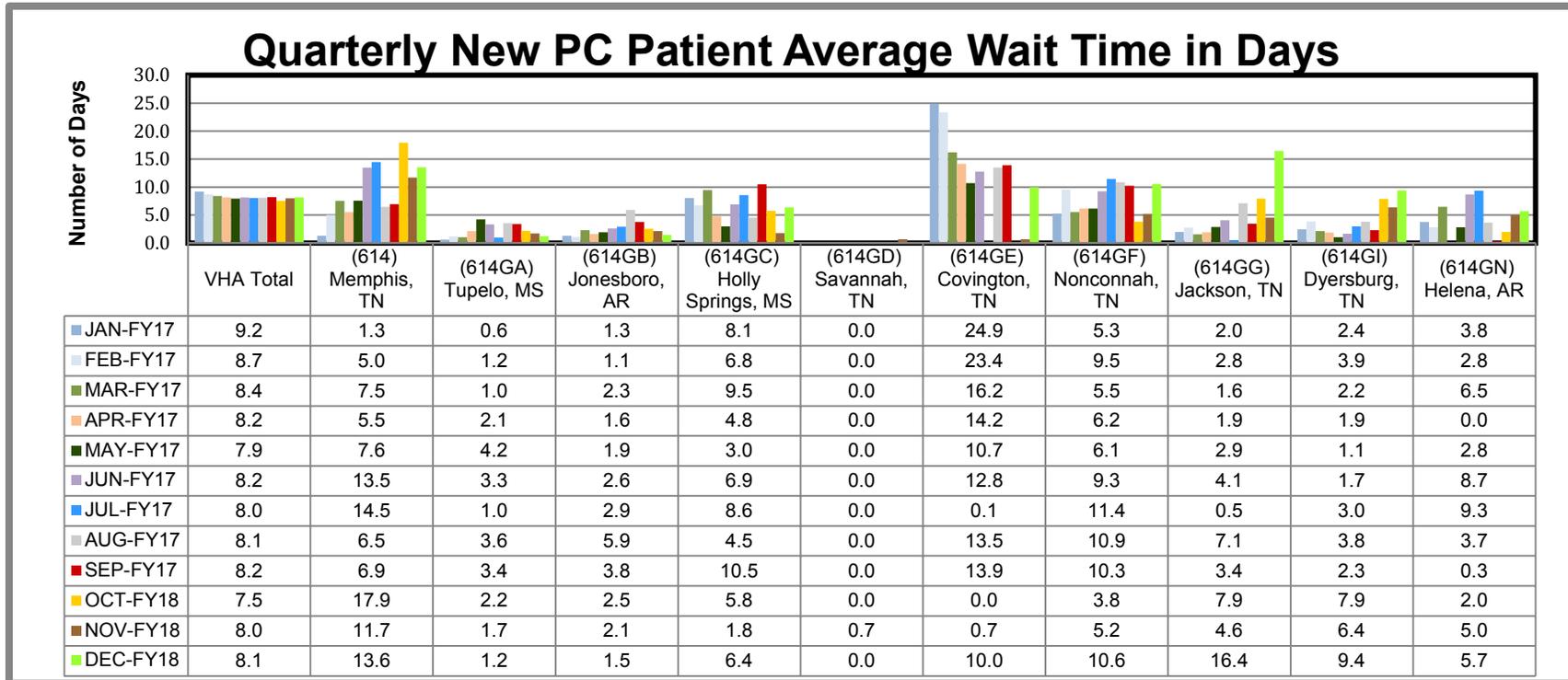
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ¹⁰⁴ Provided	Diagnostic Services ¹⁰⁵ Provided	Ancillary Services ¹⁰⁶ Provided
Savannah, TN	614GD	3,738	507	Cardiology Endocrinology	n/a	Weight Management Nutrition
Covington, TN	614GE	11,122	2,720	n/a	n/a	Nutrition Pharmacy Weight Management
Nonconnah, TN	614GF	30,899	1,489	Eye	n/a	Nutrition Pharmacy Weight Management
Jackson, TN	614GG	9,513	3,342	Endocrinology Eye	n/a	Nutrition Pharmacy Weight Management
Dyersburg, TN	614GI	4,575	894	Cardiology Endocrinology	n/a	Weight Management Nutrition
Helena, AR	614GN	2,043	714	n/a	n/a	Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁰⁷



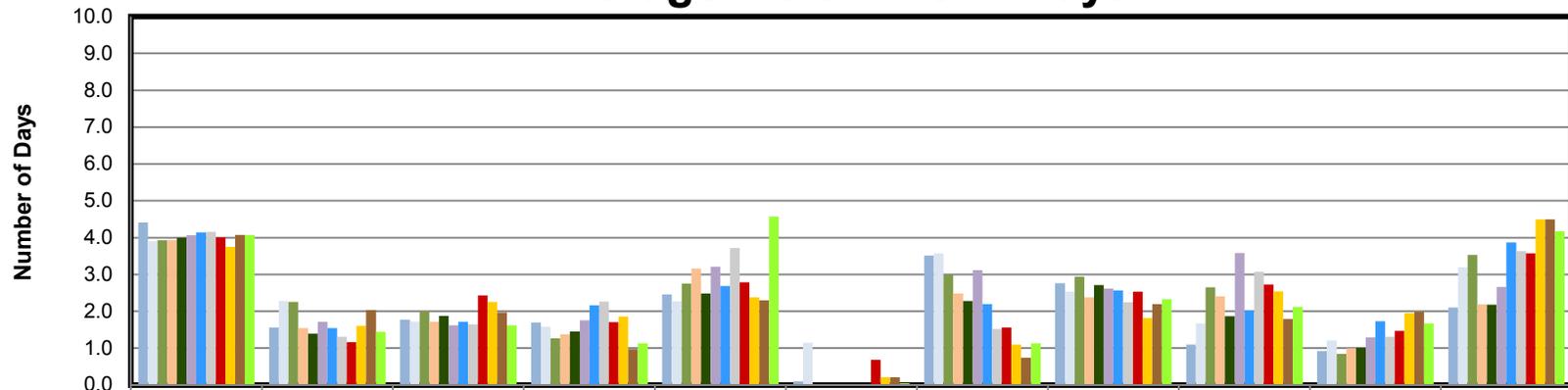
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY 2015, this metric was calculated using the earliest possible create date.

¹⁰⁷ Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed January 17, 2018.

Quarterly Established PC Patient Average Wait Time in Days



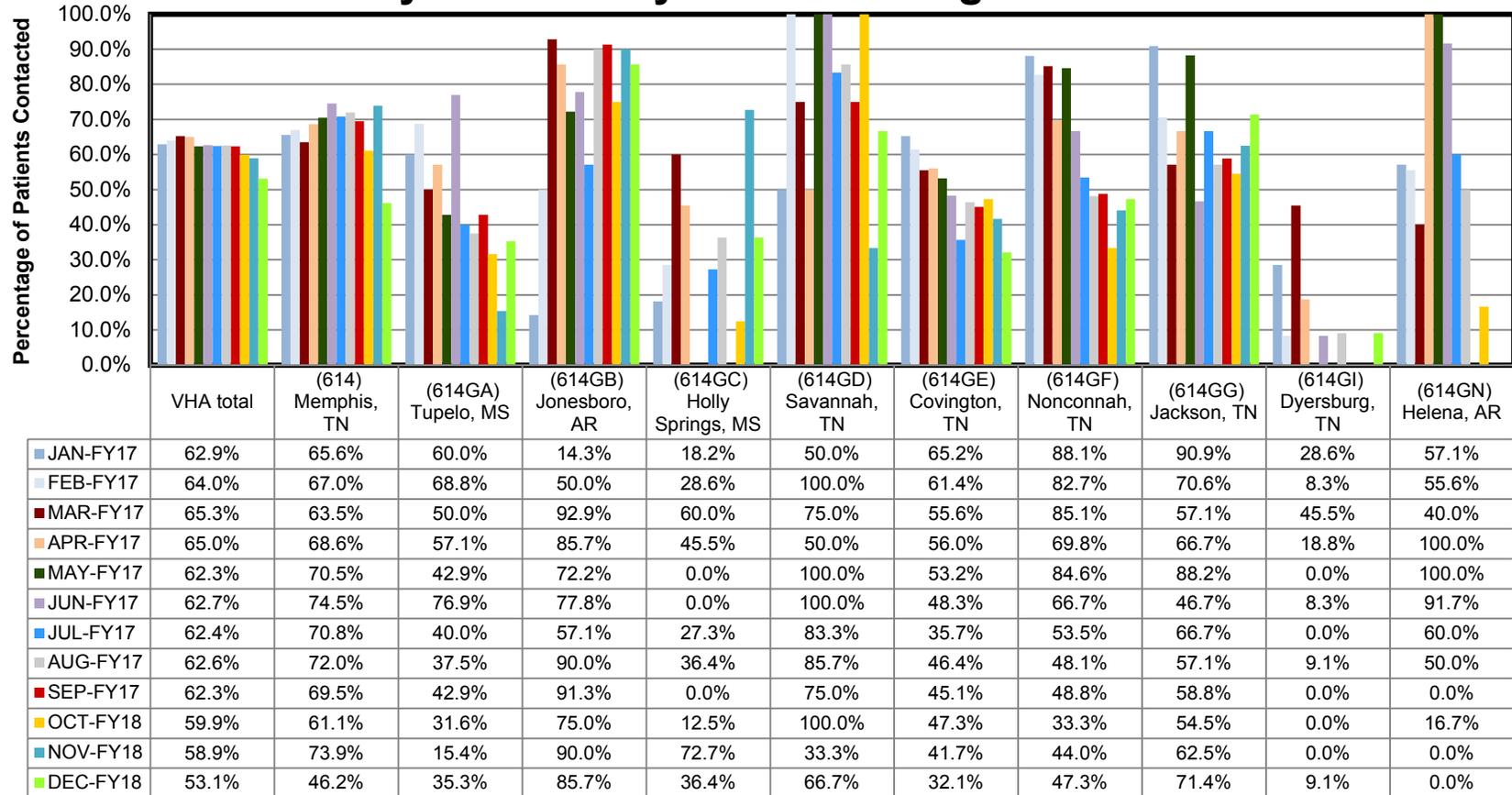
	VHA Total	(614) Memphis, TN	(614GA) Tupelo, MS	(614GB) Jonesboro, AR	(614GC) Holly Springs, MS	(614GD) Savannah, TN	(614GE) Covington, TN	(614GF) Nonconnah, TN	(614GG) Jackson, TN	(614GI) Dyersburg, TN	(614GN) Helena, AR
JAN-FY17	4.4	1.6	1.8	1.7	2.5	0.1	3.5	2.8	1.1	0.9	2.1
FEB-FY17	3.9	2.3	1.7	1.6	2.3	1.1	3.6	2.5	1.7	1.2	3.2
MAR-FY17	3.9	2.3	2.0	1.3	2.8	0.0	3.0	2.9	2.7	0.8	3.5
APR-FY17	3.9	1.5	1.7	1.4	3.2	0.0	2.5	2.4	2.4	1.0	2.2
MAY-FY17	4.0	1.4	1.9	1.4	2.5	0.0	2.3	2.7	1.9	1.0	2.2
JUN-FY17	4.1	1.7	1.6	1.8	3.2	0.0	3.1	2.6	3.6	1.3	2.7
JUL-FY17	4.1	1.5	1.7	2.2	2.7	0.0	2.2	2.6	2.0	1.7	3.9
AUG-FY17	4.2	1.3	1.6	2.3	3.7	0.0	1.5	2.2	3.1	1.3	3.6
SEP-FY17	4.0	1.2	2.4	1.7	2.8	0.7	1.6	2.5	2.7	1.5	3.6
OCT-FY18	3.7	1.6	2.3	1.9	2.4	0.2	1.1	1.8	2.5	1.9	4.5
NOV-FY18	4.1	2.0	2.0	1.0	2.3	0.2	0.7	2.2	1.8	2.0	4.5
DEC-FY18	4.1	1.4	1.6	1.1	4.6	0.0	1.1	2.3	2.1	1.7	4.2

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

Quarterly Team 2-Day Post Discharge Contact Ratio

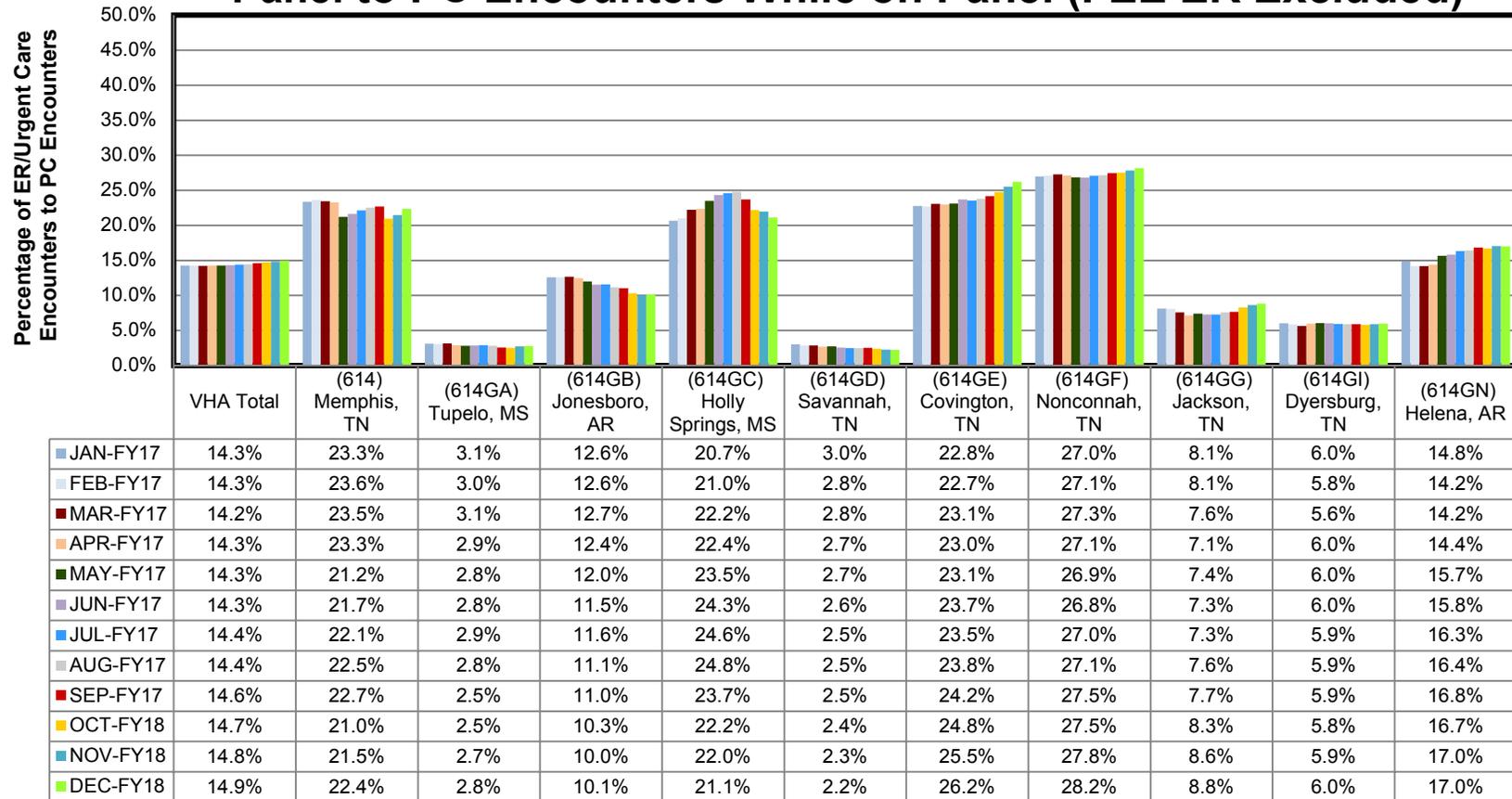


Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient’s team at the time of the patient’s discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic “PACT17.”

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁰⁸

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value

¹⁰⁸ VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 17, 2018
From: Director, VA MidSouth Healthcare Network (10N9)
Subj: CHIP Review of the Memphis VA Medical Center, Memphis, TN
To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the findings and recommendations in the OIG report entitled, Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Memphis, Tennessee. I concur with the action plans submitted by the Memphis VA Medical Center Director.


Cynthia Breyfogle, FACHE

*For accessibility, the original format of this appendix has been modified
to comply with Section 508 of the Americans with Disabilities Act.*

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 12, 2018

From: Director, Memphis VA Medical Center (614/00)

Subj: CHIP Review of the Memphis VA Medical Center, Memphis, TN

To: Director, VA MidSouth Healthcare Network (10N9)

Attached please find the VA Medical Center at Memphis, Tennessee's response and action plans to the Draft Report of the Office of Inspector General Comprehensive Healthcare Inspection Program (OIG CHIP) Review conducted January 29-February 2, 2018.



DAVID K. DUNNING, MPA

*For accessibility, the original format of this appendix has been modified
to comply with Section 508 of the Americans with Disabilities Act.*

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